Complete Summary

GUIDELINE TITLE

Phimosis. In: Guidelines on paediatric urology.

BIBLIOGRAPHIC SOURCE(S)

Phimosis. In: Tekgul S, Riedmiller H, Gerharz E, Hoebeke P, Kocvara R, Nijman R, Radmayr C, Stein R. Guidelines on paediatric urology. Arnhem, The Netherlands: European Association of Urology, European Society for Paediatric Urology; 2008 Mar. p. 6-8. [17 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Phimosis
- Paraphimosis

GUIDELINE CATEGORY

Diagnosis
Treatment

CLINICAL SPECIALTY

Pediatrics
Surgery
Urology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To outline a practical and preliminary approach to paediatric urological problems
- To increase the quality of care for children with urological problems

TARGET POPULATION

Children and adolescents with phimosis or paraphimosis

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

Physical examination for characteristics of phimosis and paraphimosis

Treatment

1. Plastic circumcision
2. Corticoid ointment or cream
3. Manual compression of the edematous tissue
4. Hyaluronidase injection
5. Incision of the constrictive ring
6. Immediate or delayed circumcision

MAJOR OUTCOMES CONSIDERED

Morbidity associated with circumcision

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guidelines were based on current literature following a systematic review using MEDLINE.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1a Evidence obtained from meta-analysis of randomized trials

1b Evidence obtained from at least one randomized trial

2a Evidence obtained from at least one well-designed controlled study without randomization

2b Evidence obtained from at least one other type of well-designed quasi-experimental study

3 Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

4 Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Application of a structured analysis of the literature was not possible due to a lack of well-designed studies. Whenever possible, statements have been classified in terms of level of evidence and grade of recommendation. Due to the limited availability of large randomized controlled trials – influenced also by the fact that a considerable number of treatment options relate to surgical interventions on a large spectrum of different congenital problems – this document is therefore largely a consensus document.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

- The first step in the European Association of Urology (EAU) guidelines procedure is to define the main topic.

- The second step is to establish a working group. The working groups comprise about 4-8 members, from several countries. Most of the working group members are academic urologists with a special interest in the topic. In general, general practitioners or patient representatives are not part of the working groups. A chairman leads each group. A collaborative working group consisting of members representing the European Society for Paediatric Urology (ESPU) and the EAU has gathered in an effort to produce the current update of the paediatric urology guidelines.
- The third step is to collect and evaluate the underlying evidence from the published literature.
- The fourth step is to structure and present the information. The strength of the recommendation is clearly marked in three grades (A-C), depending on the evidence source upon which the recommendation is based. Every possible effort is made to make the linkage between the level of evidence and grade of recommendation as transparent as possible.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation

A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial
B. Based on well-conducted clinical studies, but without randomized clinical studies
C. Made despite the absence of directly applicable clinical studies of good quality

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

There is no formal external review prior to publication.

The Appraisal of Guidelines for Research and Evaluation (AGREE) instrument was used to analyse and assess a range of specific attributes contributing to the validity of a specific clinical guideline.

The AGREE instrument, to be used by two to four appraisers, was developed by the AGREE collaboration (www.agreecollaboration.org) using referenced sources for the evaluation of specific guidelines. (See the "Availability of Companion Documents" field for further methodology information).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence (**1a-4**) and grades of recommendation (**A-C**) are defined at the end of the "Major Recommendations" field.

Diagnosis

The diagnosis of phimosis and paraphimosis is made by physical examination.

If the prepuce is not retractable or only partly retractable and shows a constrictive ring on drawing back over the glans penis, a disproportion between the width of the foreskin and the diameter of the glans penis has to be assumed. In addition to the constricted foreskin, there may be adhesions between the inner surface of the prepuce and the glanular epithelium and/or a fraenulum breve. A fraenulum breve leads to a ventral deviation of the glans once the foreskin is retracted. If the tip remains narrow and glanular adhesions were separated, than the space is filled with urine during voiding causing the foreskin to balloon outward.

The paraphimosis is characterized by retracted foreskin with the constrictive ring localized at the level of the sulcus, which prevents replacement of the foreskin over the glans.

Treatment

Treatment of phimosis in children is dependent on the parents' preferences and can be plastic or radical circumcision after completion of the second year of life. Plastic circumcision has the objective of achieving a wide foreskin circumference with full retractability, while the foreskin is preserved (dorsal incision, partial circumcision). However, this procedure carries the potential for recurrence of the phimosis. In the same session, adhesions are released and an associated fraenulum breve is corrected by fraenulotomy. Meatoplasty is added if necessary.

An absolute indication for circumcision is secondary phimosis. The indications in primary phimosis are recurrent balanoposthitis and recurrent urinary tract infections in patients with urinary tract abnormalities (**Level of evidence: 2, Grade B recommendation**). Simple ballooning of the foreskin during micturition is not a strict indication for circumcision.

Routine neonatal circumcision to prevent penile carcinoma is not indicated. Contraindications for circumcision are coagulopathy, an acute local infection and congenital anomalies of the penis, particularly hypospadias or buried penis, because the foreskin may be required for a reconstructive procedure. Childhood circumcision has an appreciable morbidity and should not be recommended without a medical reason (**Level of evidence: 2, Grade B recommendation**). As a conservative treatment option of the primary phimosis, a corticoid ointment or cream (0.05-0.1%) can be administered twice a day over a period of 20 to 30 days (**Level of evidence: 1, Grade A recommendation**). This treatment has no side effects and the mean bloodspot cortisol levels are not significantly different

from an untreated group of patients (**Level of evidence: 1**). Agglutination of the foreskin does not respond to steroid treatment (**Level of evidence: 2**).

Treatment of paraphimosis consists of manual compression of the oedematous tissue with a subsequent attempt to retract the tightened foreskin over the glans penis. Injection of hyaluronidase beneath the narrow band may be helpful to release it (**Level of evidence: 4, Grade C recommendation**). If this manoeuvre fails, a dorsal incision of the constrictive ring is required. Depending on the local findings, a circumcision is carried out immediately or can be performed in a second session.

Definitions:

Levels of Evidence

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CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for some of the recommendations (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Appropriate diagnosis and treatment of phimosis and paraphimosis
- Prevention of necrosis

POTENTIAL HARMS

- Plastic circumcision carries the potential for recurrence of phimosis
- Circumcision-related morbidity

CONTRAINDICATIONS

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Contraindications for circumcision are coagulopathy, an acute local infection and congenital anomalies of the penis, particularly hypospadias or buried penis, because the foreskin may be required for a reconstructive procedure.

QUALIFYING STATEMENTS

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The purpose of these texts is not to be proscriptive in the way a clinician should treat a patient but rather to provide access to the best contemporaneous consensus view on the most appropriate management currently available. European Association of Urology (EAU) guidelines are not meant to be legal documents but are produced with the ultimate aim to help urologists with their day-to-day practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The European Association of Urology (EAU) Guidelines long version (containing all 19 guidelines) is reprinted annually in one book. Each text is dated. This means that if the latest edition of the book is read, one will know that this is the most updated version available. The same text is also made available on a CD (with hyperlinks to PubMed for most references) and posted on the EAU websites Uroweb and Urosource (www.uroweb.org/professional-resources/guidelines/ & http://www.urosource.com/diseases/).

Condensed pocket versions, containing mainly flow-charts and summaries, are also printed annually. All these publications are distributed free of charge to all (more than 10,000) members of the Association. Abridged versions of the guidelines are published in European Urology as original papers. Furthermore, many important websites list links to the relevant EAU guidelines sections on the

association websites and all, or individual, guidelines have been translated to some 15 languages.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Phimosis. In: Tekgul S, Riedmiller H, Gerharz E, Hoebeke P, Kocvara R, Nijman R, Radmayr C, Stein R. Guidelines on paediatric urology. Arnhem, The Netherlands: European Association of Urology, European Society for Paediatric Urology; 2008 Mar. p. 6-8. [17 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Mar

GUIDELINE DEVELOPER(S)

European Association of Urology - Medical Specialty Society
European Society for Paediatric Urology - Medical Specialty Society

SOURCE(S) OF FUNDING

European Association of Urology

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Authors: S. Tekgül; H. Riedmiller; E. Gerharz; P. Hoebeke; R. Kocvara; R. Nijman; Chr. Radmayr; R. Stein

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the working group submit a conflict of interest form. The information is kept on file in the European Association of Urology (EAU) Central Office database. This guidelines document was developed with the financial support of the EAU. No external sources of funding and support have been involved. The EAU is a non-profit organisation and funding is limited to administrative assistance, travel, and meeting expenses. No honoraria or other reimbursements have been provided.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the European Association of Urology Web site.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- EAU guidelines office template. Arnhem, The Netherlands: European Association of Urology (EAU); 2007. 4 p.
- The European Association of Urology (EAU) guidelines methodology: a critical evaluation. Arnhem, The Netherlands: European Association of Urology (EAU); 18 p.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on November 13, 2008. The information was verified by the guideline developer on December 19, 2008.

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